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ABSTRACT

There are problems in using the traditional approaches of psychotherapy with various ethnic minority and national groups in the United States. Mental health practitioners, besides making errors in diagnosis, may also be handicapped in developing a therapeutic relationship with the patient. Numerous studies indicate that sociocultural factors tend to influence the efficiency of psychotherapy. Social class, racial status, and command of English all affect patient-therapist communication. Those who most frequently seek and persist in therapy are upper-middle to upper class and about half are Jews. Although some techniques have begun to be developed for dealing with lower class minority patients more research is necessary. Poor prognosis for lower class clients has more to do with attitudes of the therapist than attributes of the client (Lerner and Fiske, 1973). Hollingshead and Redlich (1958) found that upper class patients rarely went to state mental institutions, while lower class patients often did. A realization of the importance of environmental and sociocultural factors in psychotherapy will make for a better rapport between therapist and patient and, thus, more effective treatment. (Author/WI)

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DIAGNOSTICS AND PSYCHOTHERAPY WITH MINORITY GROUPS:

The Importance of Sociocultural Factors in the Training of Clinical Psychologists

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Abstract

DIAGNOSTICS AND PSYCHOTHERAPY WITH MINORITY GROUPS:
The Importance of Sociocultural Factors in the Training of Clinical Psychologists

Victor D. Sanua, Ph.D. *

With the advent of the interdisciplinary approach to the study of human behavior, sociologists and anthropologists have made their contribution to the field of psychotherapy by special emphasis on the sociocultural variables. It is felt, however, that these efforts have been rather limited in their impact on psychologists. In general, the training of psychologists has consisted primarily in the study of personality dynamics, psychopathology, and diagnostics; but is this enough to understand the total personality? In a country such as the United States, and particularly in the large cities where many ethnic, religious, and minority groups reside, a familiarity with the culture of the clients can be very helpful in psychological assessment and psychotherapeutic interventions. The profession seems to de-emphasize the influence of the social institutions within which they provide services, and concentrates too much on individual problems to the neglect of those variables that affect general behavior.

In this paper, the author reviews his own training as a clinical psychologist in a mid-Western university. He interned in a major hospital with a large foreign-born population. Because of his familiarity with several languages, he had to administer batteries of objective and projective techniques to non-English speaking patients. He faced tremendous problems in providing valid assessment of these patients, since he could only rely on the norms learned during his training as a clinical psychologist. The author discusses some of the problems and reviews some of the literature on doing psychotherapy with minority groups. He also introduces data on the well-known epidemiological and etiological studies conducted in New Haven by Hollingshead and Redlich, and in New York the Midtown-

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Manhattan Study conducted by Leighton, Srole, Opler and Langner. He presents research data on those who seek psychotherapy, those who are selected for psychotherapy, the type of psychotherapy administered, based on the cultural background of the patients, and information on those who stay in treatment. He provides suggestion for a course which will sensitize psychologists to cultural factors in the course of their clinical work. He feels that departments of psychology have not sufficiently evolved to include in their curriculum very important material in the formation of future clinical psychologists.

DIAGNOSTICS AND PSYCHOTHERAPY WITH MINORITY GROUPS

The Importance of Sociocultural Factors in the Training of Clinical Psychologists

Victor D. Sanua Ph.D.

Research in the socio-cultural aspects of psychotherapy is of somewhat recent origin. With the advent of the new inter-disciplinary approach to the study of human behavior, sociologists and anthropologists, as well as psychiatrists and psychologists, have undertaken research in the field of psychotherapy. These efforts, however, have been rather limited in their impact. While sociologists and anthropologists, in general, are experts in delineating social and cultural groups, psychologists have shown little interest in the effect of these variables on the formation of the personality. There is no question that many psychologists have usually been well trained in the dynamics and diagnostics of personality, but is this enough to understand the total personality? In a country such as the United States of America, which has many ethnic and minority groups, a familiarity with the culture of the patient can become a real asset to the psychologist.

Training of Psychologists and the Uses of Psychological Testing with the Foreign-born

About 25 years ago I received my training in clinical psychology in a highly experimental department at a Middle-Western university. What surprised me is that not one single student in

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the department had selected sociology or anthropology as a minor in spite of the fact that these two social sciences, in addition to psychology, concern the study of man. I selected a course in social psychology in the Department of Sociology and Anthropology and found it extremely stimulating. The emphasis was on the effect of the environment on the individual's behavior, while the social psychology taught in the Department of Psychology laid more emphasis on the individual himself. While some schools such as Harvard University have established interdisciplinary departments, the rule is still that there is little or almost no interaction among these three departments in most universities and colleges.

The limitations of using psychological tests (with the U.S. norms) for the foreign-born was clearly brought to my attention when I asked female students at International House in New York a simple question from the Wechsler Bellevue Scale. The question was, "What should you do if while sitting in the movies, you were the first person to discover a fire?" The correct answer is that the person should inform a responsible individual and avoid panic. However, I received the correct response from only one U.S.-born student. The others provided answers that would indicate less control on the part of the respondents or that some action should be taken by the students, such as trying to put out the fire themselves. The U.S.-born student, while providing the correct answer, indicated further that if faced with the contingency,

she was not sure that she would quietly inform the usher of the five.

Further experiences in my career revealed the inadequacies of our training as diagnosticians. As an intern at Bellevue Medical Center with my familiarity with four languages, most of my work consisted of evaluating foreign-born patients. Using the regular norms that were given to us as students, I found that my diagnostic work was of limited use. Some of my foreign patients were consistent in giving me what I assumed were psychotic responses, but I was well aware of the fact that I was not dealing with psychotics. Later on, in analyzing the projective protocols of a normal sample of individuals of different ethnic and nationality groups on the Midtown Mental Health Project in the Department of Social Psychiatry at Cornell University Medical School, I reached the same conclusion: that it is inappropriate to apply American norms to the foreign-born, even with those who have been in the United States for a long period of time.

It is to be noted that a few years ago a number of Puerto Rican children were wrongly diagnosed as mentally retared on the basis of norms given for standardized I.Q. tests and were institutionalized at Willowbrook State Hospital.

Problems of Therapy with
Ethnic and Religious Groups

There are problems in using the traditional approaches of psychotherapy with various ethnic minority groups and national

groups in the United States. Mental health practitioners, besides making errors of diagnosis, may also be handicapped in developing a therapeutic relationship with the patient. A striking example is the one reported by Abel (1956) concerning a northern doctor who misinterpreted the behavior of a patient from a southern rural community who had stated that she was speaking to Jesus about her troubles. On that basis alone, the doctor diagnosed her as a schizophrenic. Later, however, it was disclosed that the patient belonged to a religious sect in a part of the country where everyone communicates with Jesus when in trouble.

Spiegel (1959) focussed on cultural factors as they affect the phenomena of transference and countertransference. As an illustration he cited an Irish patient whose reticence simply reflected a value orientation that discouraged disclosure of intimate details about himself to family or friends, let alone to a total stranger! In such a case, a therapist might decide to stop the therapy because his patient is "too well-defended." Spiegel found that middle-class Americans tend to be future-oriented and emphasize "doing" while the Italians and the Irish emphasize "being". We must note, however, that this latter characteristic could typify lower-class Irish and Italians, and, therefore, the author may err in comparing middle-class Americans and lower-class Italians and Irish.

A study by Marcozzi and de Maria (1957) showed that there are basic differences in personality between Italians from the North and Italians from the South. Those from the North tend to have middle-class values while those from the South do not. Presumeably, Spiegel's experience has been with Italian immigrants from the South.

There is no question that socio-cultural factors tend to influence the efficiency of psychotherapy. Unfortunately students in psychotherapy receive little sensitization to these variables. The function of psychotherapy usually is clearly understood by a very small number of patients, possibly upper-middle and upper-class. Some may feel that the function of the therapist is to provide a prescription to relieve their troubles. Hollingshead and Redlich (1958) report a striking example of therapists who do not take into account the social background of their patients. The following passage was selected from their book:

> "One woman whose therapist was convinced that she understood what he was doing after a year of 'insight' therapy was asked during an interview by a different psychiatrist what she thought was occuring in her treatment. She stated, "The doctor is wonderful; he tells me how to forget" (p. 339).

Besides social class there is the problem of communication when the patient has a poor command of the English language. There is further the problem of the race of the therapist, who

may be white, while the patient may be black, and vice-versa. The matter of transference between a white and a black is filled with complexities. Kardiner and Ovesey (1951) conducted one of the first systematic studies of Black patients in therapy by combining historical, sociological and psychological information on them. Singer (1967) wrote on some of the implications of differential psychiatric treatment of black and white patients. Lerner (1972) has recently written a book on psychotherapy with blacks which will be discussed elsewhere in this paper.

Empirical Studies on Psychotherapy

A number of studies have tried to relate socio-cultural factors to the person seeking psychotherapy, the person selected for psychotherapy, the type of therapy administered; and the patient with psychotherapy and treatment. Later in this paper I shall present some of the findings of two large-scale epidemiological studies pertaining to the prevalence of treated mental illness in various social and religious groups.

Draguns (1975) recently discussed the complexities of taking a world-wide view of psychotherapy. While his emphasis is on the process of socialization process in different cultures, his views could be considered appropriate for the United States, since a large percentage of its population is either foreign born or still affected by values and traditions of foreign-born parents.

He indicated that on the basis of the accumulated data, it is safe to say that psychopathology is culturally plastic in its patterns of manifestation throughout the world. Amelioration of culturally divergent pathways of maladaptation should be effected by various means. He gives the example that with the Japanese, because of the nonintellectualized, immediate, spontaneous modes of expressing symptoms, the preference is for the therapies that are either somatic in nature or behavioral, in contrast to procedures predicated upon reconstruction and analysis of past experience.

A. Who Seeks Psychotherapy?

Eichler and Lirtzman (1956) analyzed the religious background of the patients in a V.A. psychiatric out-patient clinic located in New York City. They found that while Jews represent only 25 per cent of the population in New York, 50 per cent of the patients were Jewish. Protestants and Catholics were underrepresented.

Two major interpretations may be offered in explaining these findings: (1) either Jews submit more readily to therapy because they are less inclined to find it to conflict with their religious values or beliefs; or (2) the figures reflect the incidence of pathology, i.e., there is more psychopathology among Jews. Education was not an important variable in this study, since the three groups had similar educational backgrounds.

In a study of patients who sought psychoanalysis Weintraub and Aronson (1968) found that in the Baltimore area, where there are relatively few Jews, 40 per cent of the patients seen were Jewish, and 13 per cent were Catholic. Thus, Catholics are under-represented in an area that is highly Catholic.

Srole, Langner, Michael and Opler in their Midtown Study (1962) reported similar findings. More non-Jews were admitted to state mental hospitals, yet more Jews were treated in private mental hospitals and by private therapists. The disparity between the two groups is greatest for outpatients, where the ratio of Jew to non-Jew is 4 to 1. These figures suggest that Jews suffer from relatively milder psychological disturbances which can be dealth with adequately in an out-patient setting. Table 1 summarizes the rates of mental illness in the three major religious groups.

Table 1 -- Rates of Mental Illness per 100,000 in the Midtown Census

	HOSPITALS			
Religious Group	Public	Private	Out-Patient	Total
Jews	250	148	380	778
Protestants	385	61	103	549
Catholics	659	33	108	800

According to Srole and Langner (1962), the very low percentage of serious mental impairment among Jews is due to the

following reasons:

> "...mobilization of anxiety about the instability of the Jewish exilic environment may historically have been established as a conditioning pattern of the Jewish family structure. In one direction, such anxiety, subsequently magnified in the adult by extrafamily life conditions, may be reflected in our findings of an unusually large concentration of Midtown Jews in the subclinical mild category of symptom formation. On the other hand, this large component of historically realistic anxiety, as generated in the Jewish family, may function prophylactically to immunize its children against the potentially disabling sequelae of the more severe pressures and traumas of existence."

The findings in the New Haven Study, conducted by Hollingshead and Redlich (1958), were similar. Jews in New Haven have a higher ambulatory treatment rate than either Protestants or Catholics. Orlansky (1946) attributes the higher incidence of neurosis among Jews to the following causes: (a) conflict between Mosaic laws and an unconscious "incest motive" resulting from exceptionally close ties within Jewish families; (b) Jewish self-exclusion from manual labor and seclusion in a predominantly cerebral life; and (c) the tensions of minority life.

Schofield (1964) discovered the Yanus syndrome. Those who are in therapy tend to be youthful, attractive, verbal, intelligent and successful. Spear et al. (1968) conducted a comparative study of middle- and lower-class families in treatment at a child guidance clinic. Lower class families were less likely to keep appointments. Middle class families were more likely to bring their oldest (or only) child in as a patient, while in the lower

class it was the youngest who were more likely to appear as the referred patient.

Epidemiological Studies: The New Haven and The Midtown Manhattan Mental Health Studies

Most studies discussed so far deal primarily with outpatient populations. Two major epidemiological studies in New Haven and New York endeavored to estimate the extent of the total treated prevalence of mental illness (New Haven) and treated and untreated prevalence of mental illness (New York).

In the Midtown Study, Srole and coworkers (1962) found that the treatment prevalence was highest for upper-class patients, obviously because they could afford psychotherapy. Approximately 50 per cent of the treated patients were seen in the office of practitioners. However, they found that in the general population there is more psychiatric impairment among the lower classes (33 percent as compared to 17 percent). Thus, the impairment prevalence rate, which was obtained by interviewing a sample of 1,660 individuals, does not coincide with treatment prevalence. While the individuals of the upper class are healthier, they "pour" a larger proportion into treatment than the "most impairment laden" lowest classes. The Midtown Study included only patients who had been in mental institutions for five years. In the New Haven Study there was no such selection. In general, the lower class is unduly weighed down by a "slag heap" deposit of custodial patients in public hospitals. Since lower-class patients have a higher

frequency of psychiatric impairment and since psychiatric facilities are geared to the treatment of the middle- and upper-class patient, it would seem that the poor are getting very short shrift indeed from the vast majority of professional therapists.

In the Midtown Study 98 per 100,000 of the upper-class patients were in public mental hospitals, while 646 per 100,000 of the lower-class patients were in such institutions. On the other hand, 1,440 patients per 100,000 upper-class patients were visiting office therapists. The rate for the lower-class patients was 178 per 100,000.

In the New Haven Study the figures were as follows: 89 per 100,000 upper-class patients were in public institutions as compared to 1,500 per 100,000 lower-class patients. The rate of patients visiting office therapists was reversed as expected. There were 352 per 100,000 upper-class patients, while the rate for lower-class patients was 44 per 100,000. In comparing the rates of patients who go to private practitioners in both New Haven and New York, we see that the New York rate is almost four times that of New Haven. This is likely due to the fact that Manhattan has a higher concentration of psychotherapists than New Haven. Office therapists in New York outnumber therapists in New Haven by a margin of 4 to 1. In recent years more of such epidemiological studies have been conducted by Gersten et al. (1974) and by Dohrenwend (1974).

The Treatment of Lower Class Patients

A few studies have already appeared about some of the changes that have been introduced by therapist who deal with lower-class patients, and it is hoped that many more such studies will appear in the future. It is only in the last few years that the status of the poor in American life has become salient, particularly with the writings of Harrington (1963). They include Appalachian whites, Puerto Ricans, Mexican-Americans, Blacks and American Indians. All these groups appear to be concentrated in geographical areas rather than distributed.

Goldstein (1973) provides one of the most elaborate and empirically rigorous attempts to adopt therapeutic methods to the needs of less privileged clients. He has tapes and instructions for developing skills with poor clients and depends heavily on modeling, role playing and other behavioral techniques. Mayer and Timms (1970) found that working-class patients dislike the more aloof, non-directive, insight-oriented type of therapist. Strupps and Bloom (1973) have developed an effective role-induction film to conduct group psychotherapy with lower-class patients. Warren and Rice (1972) and Lorion (1973) provide suggestions for improving methods with these clients. Both Gould (1967) and Blanco and Akabas (1968) have suggested flexibility about the place and the length of the therapeutic sessions. The former may meet his patients in a bar, the latter may advocate visiting the factory site. Lerner and Fiske (1973) have shown that poor prognosis for

lower-class clients has more to do with attitudes of the therapist than the attributes of the client.

Psychotherapy with the black patient presents an even more serious problem, since the factor of color is to be added to his lower-class status. Lerner (1972) provides statistical evidence that white therapists can have significant effects on lower-class blacks and severely disturbed clients. However, all these are the beginnings of a movement, and it will take some time before therapists and agencies familiarize themselves with this new literature.

Other Major Variables in Psychotherapy

Referral for psychotherapy does not mean a patient will automatically receive it. Often the important variable is the personal preference of the psychotherapist. Schaffer and Myers (1954) analyzed the process of selecting patients in New Haven. Those who belonged to the professional and executive class were assigned to the senior staff while lower-class patients were assigned to medical interns. The type of treatment that the patient receives is also influenced by his background. Hollingshead and Redlich (1958) found that upper-class patients rarely went to state mental institutions (7.7%) as compared to lwer-class patients (92%). While 90% of the lower-class patients receive organic therapy, less than 50% of the upper-class patients receive similar treatment. The rest of the patients received some kind of dynamic therapy. Bailey and his co-workers (1959) found that two factors

in general predict the length of stay in treatment -- the number of years of schooling and former experience in psychotherapy. Research as to those who improved and remained outside the hospital is rather sparse. Myers et al. (1964) conducted a follow-up study of the schizophrenics who were seen ten years earlier during the large-scale, epidemiological study in New Haven. They found that while more upper-class patients were released from the hospital, their prospects were poorer, since they had a higher rate of readmission. The authors hypothesize that lower-class patients must evidence practically a complete remission as a requisite for discharge from an institution. Upper-class patients are allowed outside institutions despite continued deviance.

Murphy (1969) conducted a small, international inquiry on the effectiveness of drug therapy on patients of different backgrounds. The evidence is that some cultural backgrounds facilitate the patient's acceptance of pharmacological, as well as social and psychological, efforts.

Conclusions

The complexities of the interaction of the individual and his cultural milieu are rarely examined in psychotherapy. The therapist dimension and dynamics of the patient are always the primary focus. If one looks at the index of the scores of volumes on psychotherapy, two major words, culture and social class, hardly ever appear, indicating that such variables receive minor or no consideration in these books. This neglect of environmental factors was

recently highlighted by Bronfenbrenner (1975) when he discussed the status of research on children in the United States. He points out that the research is useful only when the psychologist reckons with the actual conditions in which the children live and develop. He calls for research designs built around the "ecology" of human development, the properties of the "enduring environment that are critical in a child's growth." The early programs of intervention in the 1960's failed largely because research was blind to the real contexts of children's lives.

An examination of current programs in clinical psychological training shows that it has not changed basically in the last 25 years. Even the recently-organized institutes and schools of psychology that now provide a doctorate in psychology rather than a Ph. D. still seem to be influenced by old traditions. No single course that would expose the students to the socio-cultural variables of their subjects is to be found. They may be presented in other courses, however. It is suggested here that the training of psychologists should include courses on the contributions of sociologists and anthropologists who have been working in the field of mental illness. Drive (1973) has accumulated an extensive bibliography in this field.

For a number of years this writer has been giving courses in the socio-cultural aspects of mental illness (see the bibliography), and students, in general, tend to be enthusiastic, as these studies have expanded their horizons. One student indicated that before

taking the course, when she saw a patient, she saw him in a limited framework. With the information from the course, she now sees patients in a much broader context. A realization of the importance of this new dimension will certainly make for a better rapport between the therapist and the patient, perhaps with more effective treatment.

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